FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033977

Facility Name: ATRIUM HEALTH CARE CENTER

Address: 1425 ESTES AVENUE (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 973-4780 **Fax #** (773) 973-1895

IDPA ID Number: 36-3689582-001

Date of Initial License for Current Owners: 1988

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	RICHARD S. SGARLATA
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds NA

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,560	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,963		844	9,807	8
9	SNF/PED					9
10	ICF	38,405	2,184	256	40,845	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,368	2,184	1,100	50,652	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.50%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NA

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 844

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	217,071	33,399	10,477	260,947		260,947		260,947			1
2	Food Purchase		167,387		167,387	(27,311)	140,076	(72)	140,004			2
3	Housekeeping	185,839	36,786		222,625		222,625		222,625			3
4	Laundry	39,786	23,327		63,113		63,113		63,113			4
5	Heat and Other Utilities			90,161	90,161		90,161	2,326	92,487			5
6	Maintenance	32,795	13,421	81,464	127,680		127,680	(20,669)	107,011			6
7	Other (specify):*							1,058	1,058			7
8	**TOTAL General Services**	475,491	274,320	182,102	931,913	(27,311)	904,602	(17,357)	887,245			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,437,187	13,678	19,887	1,470,752		1,470,752	(2,988)	1,467,764			10
10a	Therapy			20,484	20,484		20,484		20,484			10a
11	Activities	74,176	2,412	980	77,568		77,568	(320)	77,248			11
12	Social Services	84,854		1,694	86,548		86,548		86,548			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,596,217	16,090	46,045	1,658,352		1,658,352	(3,308)	1,655,044			16
	C. General Administration											
17	Administrative	74,415		250,080	324,495		324,495	(99,266)	225,229			17
18	Directors Fees											18
19	Professional Services			32,761	32,761		32,761	1,571	34,332			19
20	Dues, Fees, Subscriptions & Promotions			25,644	25,644		25,644	(5,267)	20,377			20
21	Clerical & General Office Expenses	64,348	42,214	89,986	196,548		196,548	(38,613)	157,935			21
22	Employee Benefits & Payroll Taxes			297,207	297,207	27,311	324,518		324,518			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,315	1,315		1,315	278	1,593			24
25	Other Admin. Staff Transportation			134	134		134	2,355	2,489			25
26	Insurance-Prop.Liab.Malpractice			47,920	47,920		47,920	2,258	50,178			26
27	Other (specify):*							13,256	13,256			27
28	**TOTAL General Administration**	138,763	42,214	745,047	926,024	27,311	953,335	(123,428)	829,907			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,210,471	332,624	973,194	3,516,289		3,516,289	(144,093)	3,372,196			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

ATRIUM HEALTH CARE CENTER
0033977
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	27,311	
2	FOOD		27,311

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number ATRIUM HEALTH CARE CENTER #0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			9,256	9,256		9,256	34,328	43,584			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							280,764	280,764			32
33	Real Estate Taxes			198,557	198,557		198,557		198,557			33
34	Rent-Facility & Grounds			564,813	564,813		564,813	(552,544)	12,269			34
35	Rent-Equipment & Vehicles							5,751	5,751			35
36	Other (specify):*											36
37	**TOTAL Ownership**			772,626	772,626		772,626	(231,701)	540,925			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	32,471	40,656	78,353	151,480		151,480		151,480			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,840	87,840		87,840		87,840			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	32,471	40,656	166,193	239,320		239,320		239,320			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,242,942	373,280	1,912,013	4,528,235		4,528,235	(375,794)	4,152,441			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(104,685)	30		9
10	Interest and Other Investment Income	(13,218)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(756)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(71,140)	21		24
25	Fund Raising, Advertising and Promotional	(180)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,639)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,758)	20		28
29	Other-Attach Schedule	(29,445)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (230,893)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(144,901)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (144,901)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (375,794)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ATRIUM HEALTH CARE CENTER

ID# 0033977

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Pharmacy Veterans Affairs	(1,950)	10	2
3	PPD Legal - 1999	(116)	19	3
4	Capitalized Repair/Maintenance	(26,859)	6	4
5	Out of State Seminar	(200)	24	5
6	Out of Period College Courses	(320)	11	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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23				23
24				24
25				25
26				26
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77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(29,445)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS	
	A. General Services												(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(72)											(72)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,326									2,326	5
6	Maintenance	(26,859)		928	5,262								(20,669)	6
7	Other (specify):*				1,058								1,058	7
8	**TOTAL General Services**	(26,931)		3,254	6,320								(17,357)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,950)		(1,038)									(2,988)	10
10a	Therapy													10a
11	Activities	(320)											(320)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,270)		(1,038)									(3,308)	16
	C. General Administration													
17	Administrative			23,693	(122,959)								(99,266)	17
18	Directors Fees													18
19	Professional Services	(116)		1,687									1,571	19
20	Fees, Subscriptions & Promotions	(5,694)		427									(5,267)	20
21	Clerical & General Office Expenses	(77,779)	100	39,066									(38,613)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(200)		478									278	24
25	Other Admin. Staff Transportation			2,355									2,355	25
26	Insurance-Prop.Liab.Malpractice			2,258									2,258	26
27	Other (specify):*			7,012	6,244								13,256	27
28	**TOTAL General Administration**	(83,789)	100	76,976	(116,715)								(123,428)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(112,990)	100	79,192	(110,395)								(144,093)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(104,685)	135,795	3,218									34,328	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,218)	293,982										280,764	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(564,813)	12,269									(552,544)	34
35	Rent-Equipment & Vehicles			5,751									5,751	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(117,903)	(135,036)	21,238									(231,701)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(230,893)	(134,936)	100,430	(110,395)								(375,794)	45

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		Atrium Bldg Partner	Chicago	Building Co.
				SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 564,813	ATRIUM BUILDING PARTNERS		$	$ (564,813)	1
2	V	21	BANK CHARGES		ATRIUM BUILDING PARTNERS		100	100	2
3	V	32	MORTGAGE INTEREST		ATRIUM BUILDING PARTNERS		293,982	293,982	3
4	V	30	DEPRECIATION		ATRIUM BUILDING PARTNERS		135,795	135,795	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 564,813			$ 429,877	$ * (134,936)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES		STAY CARE MANAGEMENT, LTD.	100.00%	$ 2,326	$ 2,326	15
16	V	6	REPAIRS AND MAINT.		STAY CARE MANAGEMENT, LTD.	100.00%	928	928	16
17	V	10	REHABILITATION CONS.		STAY CARE MANAGEMENT, LTD.	100.00%	(1,038)	(1,038)	17
18	V	17	ADMIN. SAL.-NON OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	23,693	23,693	18
19	V	19	PROFESSIONAL FEES		STAY CARE MANAGEMENT, LTD.	100.00%	1,687	1,687	19
20	V	20	DUES, SUBSCRIPTIONS		STAY CARE MANAGEMENT, LTD.	100.00%	427	427	20
21	V	21	CLERICAL & GENERAL		STAY CARE MANAGEMENT, LTD.	100.00%	39,066	39,066	21
22	V	24	SEMINARS		STAY CARE MANAGEMENT, LTD.	100.00%	478	478	22
23	V	25	ADMIN. STAFF TRAVEL		STAY CARE MANAGEMENT, LTD.	100.00%	2,355	2,355	23
24	V	26	INSURANCE		STAY CARE MANAGEMENT, LTD.	100.00%	2,258	2,258	24
25	V	27	EMPLOYEE BENEFITS		STAY CARE MANAGEMENT, LTD.	100.00%	7,012	7,012	25
26	V	30	DEPRECIATION		STAY CARE MANAGEMENT, LTD.	100.00%	3,218	3,218	26
27	V	34	BUILDING RENT		STAY CARE MANAGEMENT, LTD.	100.00%	12,269	12,269	27
28	V	35	EQUIPMENT RENTAL		STAY CARE MANAGEMENT, LTD.	100.00%	5,751	5,751	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 100,430	$ * 100,430	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	$	$	15
16	V	6	MAINT. COMP. - NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	5,262	5,262	16
17	V	7	EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%			17
18	V	7	EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	1,058	1,058	18
19	V	17	ADMIN. BONUS		STAY CARE MANAGEMENT, LTD.	100.00%			19
20	V	17	ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	25,626	25,626	20
21	V	17	ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	101,495	101,495	21
22	V	27	EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	1,224	1,224	22
23	V	27	EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	5,020	5,020	23
24	V	17	MANAGEMENT FEES	250,080	STAY CARE MANAGEMENT, LTD.	100.00%		(250,080)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 250,080			$ 139,685	$ * (110,395)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JEFF WEBSTER	OWNER	ADMIN	25.31	SEE ATTACHED	25	38.46	ALLOC SAL	$ 101,495	17-7	1
2	HOWARD WENGROW	OWNER	ADMIN	25.31	SEE ATTACHED	6	9.23	ALLOC SAL	25,626	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 127,121		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Staycare Management, LTD.
Street Address: 7313 N. Western Avenue
City / State / Zip Code: Chicago, IL 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	177,354	5	$ 8,146	$	50,652	$ 2,326	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	177,354	5	3,250		50,652	928	2
3	10	REHABILITATION CONS.	PATIENT DAYS	177,354	5	(3,636)		50,652	(1,038)	3
4	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	177,354	5	82,960	82,960	50,652	23,693	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	177,354	5	5,905		50,652	1,687	5
6	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	177,354	5	1,497		50,652	427	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	177,354	5	136,787	96,823	50,652	39,066	7
8	24	SEMINARS	PATIENT DAYS	177,354	5	1,675		50,652	478	8
9	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	177,354	5	8,245		50,652	2,355	9
10	26	INSURANCE	PATIENT DAYS	177,354	5	7,905		50,652	2,258	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	177,354	5	24,552		50,652	7,012	11
12	30	DEPRECIATION	PATIENT DAYS	177,354	5	11,266		50,652	3,218	12
13	34	BUILDING RENT	PATIENT DAYS	177,354	5	42,960		50,652	12,269	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	177,354	5	20,136		50,652	5,751	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 351,648	$ 179,783		$ 100,430	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Staycare Management, LTD.
Street Address: 7313 N. Western Avenue
City / State / Zip Code: Chicago, IL 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	19,277	19,277			1
2	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	8	5,262	2
3	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	35	1	1,603				3
4	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	5	5,291		8	1,058	4
5	17	ADMIN. BONUS	AVG. HOURS WORKED	40	1	250				5
6	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	277,610	277,610	6	25,626	6
7	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	5	263,887	263,887	25	101,495	7
8	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	5	13,264		6	1,224	8
9	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	5	13,052		25	5,020	9
10	30	DEPR.- AUTO - MINI VAN	AVG. HOURS WORKED	35	1	1,775				10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 622,319	$ 587,084		$ 139,685	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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14										14
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Alloca from Atrium Ptnrshp	X		Mortgage			$	$ 3,117,754			$ 293,982	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Due on Insurance							45,941				6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,163,695			$ 293,982	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	Interest Income		X								(13,218)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (13,218)	14
15	TOTALS (line 9+line14)						$	$ 3,163,695			$ 280,764	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	200,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	198,557	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,443)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	200,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	198,557	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	184,180	8
	1996	188,711	9
	1997	196,412	10
	1998	199,899	11
	1999	198,557	12

2000 Accrual = $200,000 Estimated

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,313 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		26,895	1972	$ 124,712	1
2					2
3	TOTALS	26,895		$ 124,712	3

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	160		1972	1972	$ 574,854	$ 114,375	33	$ 13,252	$ (101,123)	$ 574,854	4
5				1972	344,971		20			344,971	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1979	1,360		20			1,354	9
10	Various			1982	1,310		20	66	66	1,188	10
11	Various			1989	42,200	1,340	20	2,110	770	17,864	11
12	Various			1992	16,375	520	20	819	299	6,110	12
13	Various			1993	26,090	692	20	1,305	613	8,215	13
14	Various			1995	32,183	269	20	1,610	1,341	8,266	14
15	ELECTRICAL WORK			1996	2,280		20	114	114	456	15
16	DECORATING			1996	3,831		20	192	192	768	16
17	WALLPAPER			1996	7,633		20	382	382	1,528	17
18	HANDRAILS			1996	4,015		20	201	201	804	18
19	BOILER PARTS			1996	2,428		20	121	121	484	19
20	NEW ROOF			1996	46,800	1,200	20	2,340	1,140	11,310	20
21	WATER HEATER			1996	4,617	118	20	231	113	1,059	21
22	DUET EXHAUST			1997	2,284		20	114	114	380	22
23	IMPROVEMENT			1997	5,480	141	20	274	133	913	23
24											24
25	PAGE 12-1 REP TOTALS				168,301	3,218		262	(2,956)	161,682	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				88,852	1,518		2,998	1,479	3,302	34
35	PAGE 12A TOTALS				183,633	2,608		9,187	6,579	26,187	35
36	TOTAL (lines 4 thru 35)				$ 1,559,497	$ 125,999		$ 35,578	$ (90,422)	$ 1,171,695	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FIRE ALARM			1997	9,500		20	475	475	1,544	9
10	DRAPES			1997	4,857		20	243	243	871	10
11	WATER PUMP			1997	1,680		20	84	84	301	11
12	FIRE SYSTEM			1997	2,035		20	102	102	366	12
13	TANK UNIT			1997	3,250		20	163	163	625	13
14	ELEVATOR CYLINDER			1997	10,387		20	519	519	1,990	14
15	WALLPAPER			1997	8,570		20	429	429	1,716	15
16	WATER PIPING			1997	2,850		20	143	143	572	16
17	ELECTRIC RELAY			1997	1,791		20	90	90	323	17
18	PAINTING/DECORATING			1998	29,452		20	1,473	1,473	2,946	18
19	FIRE ALARM SYSTEM			1998	5,208	134	20	260	126	715	19
20	NEW EXHAUST SYSTEM			1998	18,110	464	20	906	442	2,643	20
21	CONSULTING-LSC			1998	1,464	38	20	73	35	189	21
22	INSULATION			1998	1,750	45	20	88	43	242	22
23	FIRE SPRINKLER WORK			1998	7,985	205	20	399	194	1,131	23
24	FIRE ALARM SYSTEM			1998	12,755	327	20	638	311	1,808	24
25	CONSULTING-LSC			1998	2,277	58	20	114	56	333	25
26	CONSULTING-LSC			1998	2,003	51	20	100	49	258	26
27	ADJ SPRINKLERS			1998	2,573	66	20	129	63	355	27
28	FIRE ALARM SYSTEM			1998	23,500	603	20	1,175	572	3,329	28
29	FIRE ALARM SYSTEM			1998	22,758	584	20	1,138	554	3,224	29
30	FIRE DOORS			1998	1,273	33	20	64	31	187	30
31	PAINTING/WALLPAPER			1999	1,650		20	83	83	90	31
32	SEWER PIPE WORK			1999	1,550		20	78	78	98	32
33	SINK PIPING			1999	565		20	28	28	35	33
34	GREASE TRAP			1999	750		20	38	38	76	34
35	DRYER EXHAUST			1999	3,090		20	155	155	220	35
36	TOTAL (lines 4 thru 35)				$ 183,633	$ 2,608		$ 9,187	$ 6,579	$ 26,187	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER HEATER			1999	5,940	152	20	297	145	569	9
10	ELEVATOR OIL PUMP			1999	708		20	35	35	50	10
11	ELEVATOR DUCT WORK			1999	1,100		20	55	55	73	11
12	ELEVATOR			2000	23,535	578	20	578		578	12
13	PAVEMENT WORK			2000	12,773	639	20	639		639	13
14	NURSES STATION			2000	19,894	149	20	149		149	14
15	CUBICLE CURTAINS			2000	680		20	34	34	34	15
16	PA SERVICE			2000	887		20	44	44	44	16
17	GENERATOR			2000	629		20	31	31	31	17
18	FIRE ALARM SYSTEM			2000	770		20	39	39	39	18
19	PAVEMENT WORK			2000	1,190		20	60	60	60	19
20	NURSE CALL SYSTEM			2000	1,160		20	58	58	58	20
21	SPRINKLER SYSTEM			2000	2,428		20	121	121	121	21
22	GENERATOR			2000	3,200		20	160	160	160	22
23	NURSE STATIONS			2000	9,947		20	497	497	497	23
24	FIRE DAMPERS			2000	804		20	40	40	40	24
25	AIR VENTS			2000	3,207		20	160	160	160	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 88,852	$ 1,518		$ 2,998	$ 1,479	$ 3,302	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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14											14
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17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION FROM STAYCARE			1992	4,986	112	20	249	137	2,200	9
10	ALLOCATION FROM STAYCARE			2000	3,106	3,106	20	13	(3,093)	13	10
11	GREENVIEW PAVILION CONVALESCENT CENTER			1978	8,562		10			8,562	11
12	GREENVIEW PAVILION CONVALESCENT CENTER			1979	10,316		10			10,316	12
13	GREENVIEW PAVILION CONVALESCENT CENTER			1980	12,652		10			12,652	13
14	GREENVIEW PAVILION CONVALESCENT CENTER			1981	4,095		10			4,095	14
15	GREENVIEW PAVILION NURSING HOME			1972	42,000		20			42,000	15
16	GREENVIEW PAVILION NURSING HOME			1972	8,343		15			8,343	16
17	GREENVIEW PAVILION NURSING HOME			1974	12,941		20			12,941	17
18	GREENVIEW PAVILION NURSING HOME			1977	46,500		20			46,500	18
19	GREENVIEW PAVILION NURSING HOME			1978	14,800		20			14,060	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 168,301	$ 3,218		$ 262	$ (2,956)	$ 161,682	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 74,980	$ 21,855	$ 7,500	$ (14,355)		$ 34,950	37
38	Current Year Purchases	2,372	415	181	(234)		181	38
39	Fully Depreciated Assets	323,026		326	326		71,589	39
40								40
41	TOTALS	$ 400,378	$ 22,270	$ 8,007	$ (14,263)		$ 106,720	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,084,587	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 148,269	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 43,585	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (104,685)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,278,415	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

ATRIUM HEALTH CARE CENTER
0033977
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Atrium Healthcare Center	55,869	435	5,588	5,153	22,785
Staycare Management	19,111		1,912	1,912	12,165
Atrium Healthcare Center LTD. Partnership		21,420		(21,420)	
Greenview Convalescent					
Greenview Nursing Home					
TOTALS	74,980	21,855	7,500	(14,355)	34,950
LINE 29: CURRENT YEAR					
Atrium Healthcare Center	2,372	415	181	(234)	181
Staycare Management					
Atrium Healthcare Center LTD. Partnership					
Greenview Convalescent					
Greenview Nursing Home					
TOTALS	2,372	415	181	(234)	181
LINE 30: FULLY DEPRECIATED					
Atrium Healthcare Center	71,589		326	326	71,589
Staycare Management					
Atrium Healthcare Center LTD. Partnership					
Greenview Convalescent	112,727				
Greenview Nursing Home	138,710				
TOTALS	323,026		326	326	71,589
TOTALS (Should Tie to Totals on Page 13)					
Atrium Healthcare Center	129,830	850	6,095	5,245	94,555
Staycare Management	19,111		1,912	1,912	12,165
Atrium Healthcare Center LTD. Partnership		21,420		(21,420)	
Greenview Convalescent	112,727				
Greenview Nursing Home	138,710				
TOTALS	400,378	22,270	8,007	(14,263)	106,720

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GREENVIEW PAVILION

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	ALLOCATION FROM STAY CARE MGMNT			$ 12,269			3
4	Additions		160					4
5								5
6								6
7	TOTAL		160		$ 12,269 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 5,751 Description: Allocation from Staycare
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	2146 hrs	$ 17,679		$ 32,904		$	2,146	$ 50,583	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,258				1,258	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	2345 hrs	14,792		44,192			2,345	58,984	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					16,159		16,159	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**							24,497		24,497	13
14	TOTAL			$ 32,471		$ 78,354		$ 40,656	4,491	$ 151,481	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	BLOOD GLUCOSE - LAB SUPPLIES	24,422
2	LAB AND RADIOLOGY SERVICES	75
3		
4		
5		
6		
7		
8		
9		
10		
		24,497

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 489,158	$ 489,147	1
2	Cash-Patient Deposits	40,762	40,762	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	868,073	868,073	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,457	71,457	6
7	Other Prepaid Expenses	875	875	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,470,325	$ 1,470,314	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		260,000	13
14	Buildings, at Historical Cost		4,460,623	14
15	Leasehold Improvements, at Historical Cos	315,849	315,849	15
16	Equipment, at Historical Cost	125,489	605,489	16
17	Accumulated Depreciation (book methods)	(167,288)	(1,490,804)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	97,131	97,131	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 371,181	$ 4,248,288	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,841,506	$ 5,718,602	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 63,283	$ 63,283	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,634	40,634	28
29	Short-Term Notes Payable	45,941	45,941	29
30	Accrued Salaries Payable	97,249	97,249	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,221	3,221	31
32	Accrued Real Estate Taxes(Sch.IX-B)	200,000	200,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,635	6,635	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	48,768	48,768	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 505,731	$ 505,731	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,117,754	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,117,754	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 505,731	$ 3,623,485	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,335,775	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,841,506	$ #REF!	48

*(See instructions.)

Facility Name & ID Number ATRIUM HEALTH CARE CENTER **#** 0033977 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount

OTHER CURRENT LIABILITIES:	Amount	Amount
Exchange	1,650	1,650
Hospice	27,588	27,588
Deferred Income	19,530	19,530
	48,768	48,768

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Real Estate Tax Escrow	97,131	97,131
	97,131	97,131

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,140,503	1	
2	Restatements (describe):		2	
3	Schedule attached		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,140,503	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	435,272	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(240,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 195,272	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,335,775	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	ATRIUM HEALTH CARE CENTER	#	0033977	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,140,503
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,140,503
Equity(Deficit) from Page 17 Col 1		1,335,775
Related Party		
Equity(Deficit)	624406	
Income	134936	
		759,342
Combined Equity - End of Year		2,095,117

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,616,462	1
2	Discounts and Allowances for all Levels	(35,969)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,580,493	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	288,305	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 288,305	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	248	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,389	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,498	19
20	Radiology and X-Ray		20
21	Other Medical Services	7,356	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 81,491	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,218	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,218	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,963,507	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	931,913	31
32	Health Care	1,658,352	32
33	General Administration	926,024	33
	B. Capital Expense		
34	Ownership	772,626	34
	C. Ancillary Expense		
35	Special Cost Centers	151,480	35
36	Provider Participation Fee	87,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,528,235	40
41	**Income before Income Taxes (line 30 minus line 40)****	435,272	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 435,272	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ATRIUM HEALTH CARE CENTEI # 0033977 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,174	2,370	$ 65,801	$ 27.76	1
2	Assistant Director of Nursing	2,173	2,370	47,649	20.11	2
3	Registered Nurses	25,235	28,686	538,141	18.76	3
4	Licensed Practical Nurses	17,300	19,816	290,917	14.68	4
5	Nurse Aides & Orderlies	53,989	59,683	476,569	7.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,491	5,313	32,471	6.11	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,246	3,570	22,755	6.37	9
10	Activity Assistants	5,828	6,002	51,421	8.57	10
11	Social Service Workers	6,755	7,447	84,854	11.39	11
12	Dietician					12
13	Food Service Supervisor	1,768	2,190	32,925	15.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,200	25,578	184,146	7.20	15
16	Dishwashers					16
17	Maintenance Workers	2,062	2,289	32,795	14.33	17
18	Housekeepers	25,007	27,340	185,839	6.80	18
19	Laundry	5,905	6,404	39,786	6.21	19
20	Administrator	1,896	2,240	74,415	33.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,397	5,027	64,348	12.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,343	1,535	18,110	11.80	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	186,769	207,860	$ 2,242,942 *	$ 10.79	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 10,477	1-3	35
36	Medical Director	Monthly	3,000	9-3	36
37	Medical Records Consultant	Monthly	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,880	10-3	39
40	Physical Therapy Consultant	65	2,933	10A-3	40
41	Occupational Therapy Consultant	366	17,551	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	980	11-3	44
45	Social Service Consultant	22	1,144	12-3	45
46	Other(specify)				46
47	Religious Services	22	550	12-3	47
48	Doctors	3	75	10-3	48
49	TOTAL (lines 35 - 48)	519	$ 43,622		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	688	12,900	10-3	52
53	TOTAL (lines 50 - 52)	688	$ 12,900		53

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ron Silver (1/1-8/31)	Administrator	0	$ 56,854
Anita Hermann (9/1-12/31)	Administrator	0	17,561
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,415

B. Administrative - Other

Description	Amount
Stay Care Management - Management Fees	$ 250,080
TOTAL (agree to Schedule V, line 17, col. 3)	$ 250,080
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sachnoff and Weaver	Legal	$ 12,214
FR&R	Accounting Fees	19,570
Personnel Planners	Unemployment Consultant	978
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,762

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,230
Unemployment Compensation Insurance	13,418
FICA Taxes	170,691
Employee Health Insurance	67,272
Employee Meals	27,311
Illinois Municipal Retirement Fund (IMRF)*	425
Chicago Head Tax	4,832
Employee Benefits	2,782
Union Pension	14,923
401 K Contributions	4,635
TOTAL (agree to Schedule V, line 22, col.8)	$ 324,519

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,000
Advertising: Employee Recruitment	10,144
Health Care Worker Background Check	
(Indicate # of checks performed 85)	850
Licenses, Permits, Fees	1,702
Dues and Subscriptions - ICLTC	6,254
Promotional Advertising	180
Yellow Page Advertising	4,758
Allocation from Staycare	427
Less: Public Relations Expense	( )
Non-allowable advertising	(180)
Yellow page advertising	(4,758)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,377

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Alloc from Staycare	478
Seminar Expense	1,315
Out-of-State Seminar	(200)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,593

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ATRIUM HEALTH CARE CENTER # 0033977 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $6,560**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,517** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
Greenview Pavilion Nursing Center - #18192

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **87,840**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **27,311** Has any meal income been offset against related costs? **NA** Indicate the amount. $ **NA**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **NA**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw